Introduction To MEDICARE

A BASIC ORIENTATION

HOSPITAL INSURANCE PART A

MEDICAL INSURANCE PART B

SOCIAL SECURITY ADMINISTRATION
BUREAU OF HEALTH INSURANCE

SS PUB 66-71 (1-72)

What is Medicare?

It's a Federal health insurance program for people 65 or over. The program was established by an act of Congress in 1965.

The Medicare program is in

2 PARTS...

I. HOSPITAL INSURANCE (PART-A)

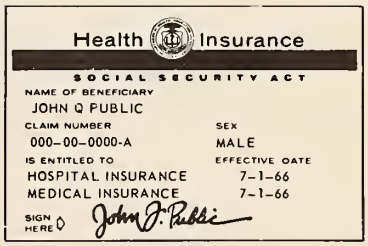
This coverage is available to nearly everyone 65 or over

II. MEDICAL INSURANCE (PART-B)

This part is voluntary and the beneficiary must sign up

MEDICARE

• HOSPITAL INSURANCE
PART A



• MEDICAL INSURANCE
PART B

Hospital insurance helps pay for medically necessary services which are covered by the program and are provided by health facilities participating in Medicare.

What is a Participating Facility?

To participate in the Medicare program, health facilities must meet standards which help assure that they will be able to provide high quality health care. In addition, they must not charge the Medicare beneficiary for services paid for by the program, and they must abide by Title VI of the Civil Rights Act, which prohibits discrimination based on race, color, or national origin.

Hospital insurance helps pay for services received when a beneficiary is:

A BED PATIENT IN A HOSPITAL
and if further care is needed after a hospital stay

A BED PATIENT IN AN EXTENDED CARE FACILITY, or

A PATIENT AT HOME RECEIVING SERVICES FROM A HOME HEALTH AGENCY

The services hospital insurance helps pay for are limited to Covered Services.

HOSPITAL INSURANCE

- A BED PATIENT IN A HOSPITAL,
- A BED PATIENT IN AN EXTENDED CARE FACILITY, or
- A PATIENT AT HOME RECEIVING SERVICES FROM A HOME HEALTH AGENCY.

The Financing of Hospital Insurance

The hospital insurance program is financed by special contributions from employees and self-employed persons, with employers paying an equal amount. These contributions are collected along with regular social security contributions from the wages and self-employment income earned during a person's working years.

These contributions are put into the Hospital Insurance Trust Fund from which the program's benefits and administrative expenses are paid.

In addition, the law provides that the various dollar amounts for which the beneficiary is responsible be reviewed annually. These dollar amounts include the first $68 of hospital charges in each benefit period and different per-day amounts after certain periods of benefit use in hospitals and extended care facilities. These are described on the following pages. The law also provides that if this annual review shows that hospital costs have changed significantly these amounts must be adjusted for the following year.

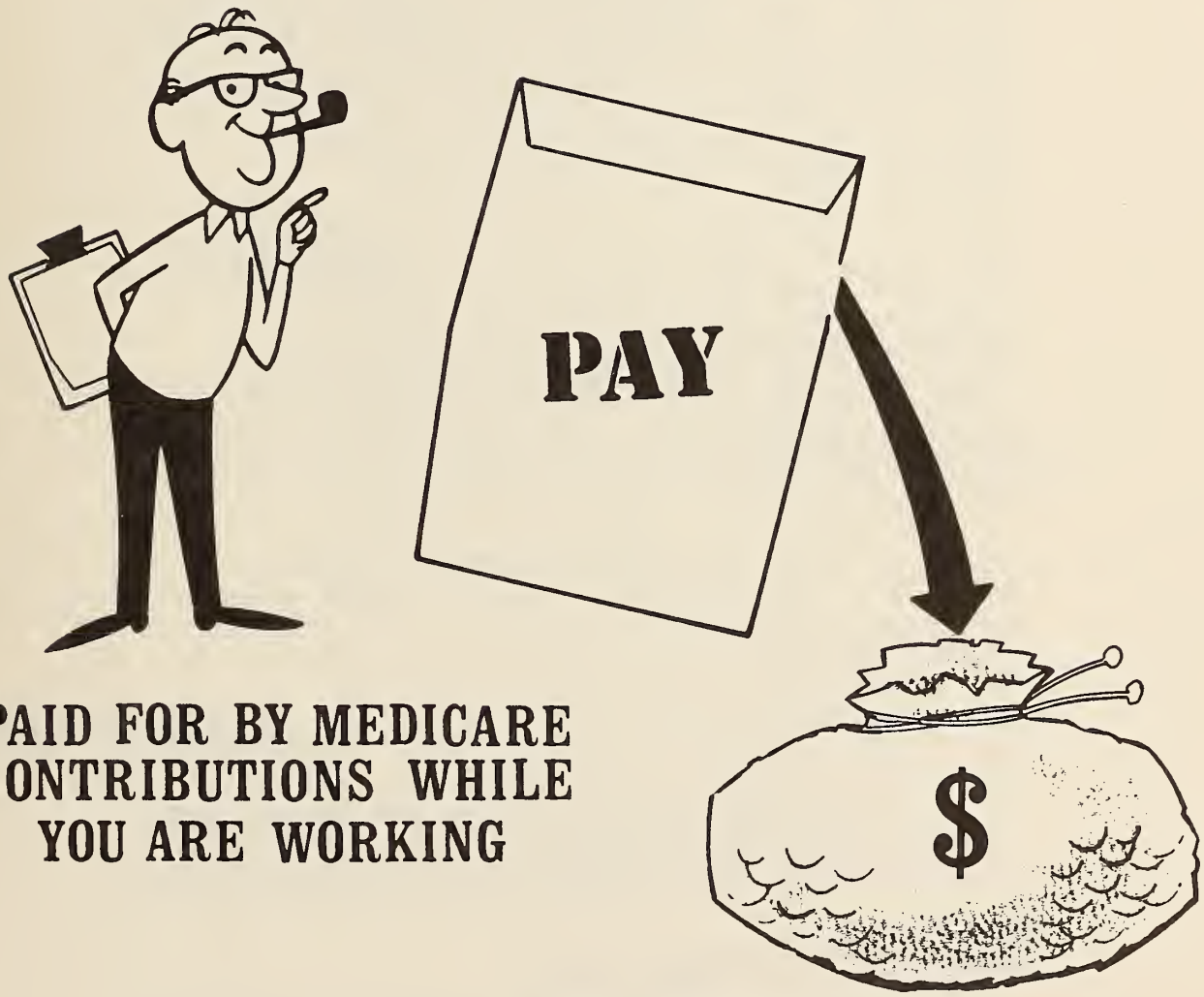
How are Hospital Insurance Benefits Counted?

When the beneficiary is a bed patient in a hospital up to 90 days are available for each benefit period.

- For the first 60 days--hospital insurance pays for all covered services, except for the first $68 (deductible)
- The 61st through the 90th day--hospital insurance pays for all covered services, except for $17 per day (coinsurance)

Note Once the beneficiary has taken care of the first $68 of hospital expenses in each benefit period he does not have to pay it back again, even if he has to go back in a hospital more than once in that same benefit period.

How Hospital Insurance Benefits Are Financed



PAID FOR BY MEDICARE CONTRIBUTIONS WHILE YOU ARE WORKING

HEALTH INSURANCE TRUST FUND

What is a Benefit Period?

A "benefit period" is simply a period of time measuring the beneficiary's use of hospital insurance benefits.

How does it work?

The first time a beneficiary enters a hospital after his hospital insurance starts will be the beginning of his first benefit period. His first benefit period ends as soon as he has not been an in-patient of any hospital (or any facility that mainly provides skilled nursing care) for 60 days in a row.

After that, a new benefit period begins the next time the beneficiary enters a hospital--and that benefit period ends as soon as he has another 60 days in a row when he is not an in-patient of any hospital (or any facility that mainly provides skilled nursing care). Then another benefit period can begin the next time he enters a hospital--and so on.

There is no limit to the number of benefit periods a beneficiary may have. There is an easy way to remember the rule. Just keep in mind that any time a beneficiary is not in any hospital or other facility mainly providing skilled nursing care for 60 days in a row, a new benefit period will begin the next time he goes into a hospital. And, of course, for each new benefit period, the beneficiary's full hospital insurance benefits are available again to use as he needs them.

Lifetime reserve?

60 additional hospital days

This is like a "bank account" of extra days to draw from if the beneficiary needs them. He can use them if he ever needs more than 90 days of hospital care in the same benefit period. For each "lifetime reserve" day used, hospital insurance pays for all covered services, except for $34 a day.

BENEFIT PERIOD

•BEGINS:

THE FIRST TIME A BENEFICIARY ENTERS A HOSPITAL AFTER HIS HOSPITAL INSURANCE BEGINS

•ENDS:

BENEFICIARY HAS NOT BEEN AN IN-PATIENT OF ANY HOSPITAL OR ANY FACILITY THAT MAINLY PROVIDES SKILLED NURSING CARE FOR 60 DAYS IN A ROW

•NO LIMIT:

THERE IS NO LIMIT TO THE NUMBER OF BENEFIT PERIODS A BENEFICIARY MAY HAVE

•LIFETIME RESERVE

60 EXTRA DAYS TO DRAW UPON IF THE BENEFICIARY NEEDS THEM

Each lifetime reserve day a beneficiary uses permanently reduces the total he has left.

Many times a beneficiary will want to use his lifetime reserve days if he needs hospital care after he has used all his 90 days in a benefit period. Unless he decides not to use them, the extra days of hospital care that he uses are automatically taken from his lifetime reserve.

If for any reason a beneficiary does not wish to use his reserve days, the hospital will ask him to say so in writing. In making his decision, he should consider any private insurance he has which may pay for some or all of his additional hospital care. And, of course, the beneficiary may wish to talk to his doctor or the people at the hospital about whether in his particular situation he should draw on his lifetime reserve.

EXAMPLE: Mr. Beneficiary had to go to the hospital a number of times in the same benefit period and used up all his 90 days. Before a new benefit period could start, he again needed to go to a hospital. Mr. B. can draw from his "lifetime reserve" days to help him pay for the hospital care.

Note.

The beneficiary doesn't have to bother about trying to keep track of how many "days" or "visits" he uses in each benefit period. The notice he receives from the Social Security Administration after he has used any hospital insurance benefits will tell him how many benefit "days" and "visits" he has left in that benefit period. But, very few people who enter a hospital or extended care facility, or use home health services, need these services long enough to use all the benefits they have for a benefit period. So most people will never run out of "days" or "visits," because a new benefit period will almost always start with full benefits available again the next time they are needed.

EXAMPLE: Mr. Beneficiary was in the hospital for 14 days and then went home.

After being at home for 80 days, Mr. B. needs to return to the hospital. When Mr. B. is admitted this time, he is in a new benefit period. That means he is again eligible for up to 90 hospital days because more than 60 days have gone by since he was last in a hospital (or other facility that mainly provides skilled nursing care). The benefit days Mr. B. used the time before do not matter because he is in a new benefit period.

However, because Mr. B. had been in the hospital only 14 days, he still had 76 hospital benefit days left in the original benefit period. If he had had to go back to the hospital within 60 days, instead of 80, he could have used any of these remaining days he needed during this second stay.

Are Benefits Limited in Psychiatric Hospitals?

For care in a psychiatric hospital, there is a lifetime limit of 190 hospital benefit days. Also, for a beneficiary who is a patient in a psychiatric hospital on the day his hospital insurance starts, a special limitation is associated with the length of the first benefit period.

Hospital Benefits

The lists below describe the kinds of benefits that hospital insurance will help pay for when the beneficiary is a bed patient in a hospital and some of the services that it cannot pay for.

COVERED INPATIENT HOSPITAL SERVICES

Semiprivate room (2, 3, 4 beds); private if medically necessary. All meals including special diets.

Operating room charges.

Nursing services.

Drugs furnished by hospital.

Laboratory tests.

X-ray and other radiology services.

Necessary medical supplies.

Use of appliances and equipment furnished by the hospital such as a wheelchair, crutches, and braces.

Medical social services.

NONCOVERED INPATIENT HOSPITAL SERVICES

Personal comfort or convenience items furnished at patient's request.

Private duty nurses.

Any extra charge for use of a private room, unless it is medically necessary.

Noncovered levels of care.

Doctors' services. (Medical insurance helps pay for these.)

Services not reasonable and necessary for the treatment of an illness or injury.

- DRUGS
- LABORATORY TESTS
- MEDICAL SUPPLIES
- OPERATING ROOM
- NURSING SERVICES
- SEMIPRIVATE ROOM
- MEALS - SPECIAL DIETS
- APPLIANCES & EQUIPMENT
- MEDICAL SOCIAL SERVICE
- X-RAY RADIOLOGY SERVICE

- PRIVATE ROOM
- DOCTORS' SERVICES
- PRIVATE DUTY NURSES
- PERSONAL COMFORT ITEMS
- NONCOVERED LEVELS OF CARE

What are Extended Care Benefits?

Sometimes a patient no longer needs the intensive care which hospitals provide, but still needs fulltime skilled nursing care and other health services which cannot be furnished in his home. In these cases, the doctor may transfer the patient from the hospital to an extended care facility. This is a specially qualified facility which is staffed and equipped to furnish fulltime skilled nursing care and many important related health services.

Hospital insurance pays for all covered services in a participating extended care facility for the first 20 days the beneficiary receives such services in each benefit period and all but $8.50 a day for up to 80 more days in that same benefit period if all the following are true:

- Patient requires continuing skilled nursing care;
- A doctor determines that the patient needs extended care and orders it;
- The patient has had a medically necessary stay in a participating (or otherwise qualified) hospital for at least 3 days in a row before his admission;
- The patient is admitted within 14 days after he leaves the hospital; and
- The patient is admitted for further treatment of a condition for which he was treated in the hospital.

If the patient leaves an extended care facility and is readmitted to one within 14 days, he can continue to use his remaining extended care benefit days for that benefit period without a new 3-day stay in a hospital.

CONTINUING SKILLED NURSING CARE

DOCTOR DETERMINES PATIENT NEEDS EXTENDED CARE

MEDICALLY NECESSARY

- 3-DAY HOSPITAL STAY
- ADMITTED 14 DAYS AFTER DISCHARGE FROM THE HOSPITAL
- FURTHER TREATMENT OF A CONDITION RECEIVED SERVICE IN THE HOSPITAL

Extended Care Benefits

The following list describes some of the kinds of extended care services hospital insurance will help pay for and some of the services that it cannot pay for.

COVERED INPATIENT EXTENDED CARE SERVICES

Semiprivate room (2, 3, 4 beds); private if medically necessary. All meals including special diets.

Nursing services.

Drugs furnished by extended care facility.

Physical, occupational, and speech therapy.

Necessary medical supplies.

Use of appliances and equipment furnished by the facility such as a wheelchair, crutches, and braces.

Medical social services.

NONCOVERED INPATIENT EXTENDED CARE SERVICES

Personal comfort or convenience items furnished at patient's request.

Private duty nurses.

Any extra charge for use of a private room, unless it is medically necessary.

Noncovered levels of care.

Doctors' services. (Medical insurance helps pay for these.)

Services not reasonable and necessary for the treatment of an illness or injury.

Extended Care Benefits

NONCOVERED SERVICES

- Personal comfort items
- Private duty nurses
- Private room
- Doctors
- Noncovered levels of care

What are Home Health Benefits?

After the patient has had a qualifying hospital stay (or has been in an extended care facility after a qualifying hospital stay), his doctor may decide that the continued care he needs can be best given in his own home through a home health agency. If the continuing care he needs in his home includes part-time skilled nursing care or physical or speech therapy, Medicare can pay for this care and also for certain additional health care services he may need.

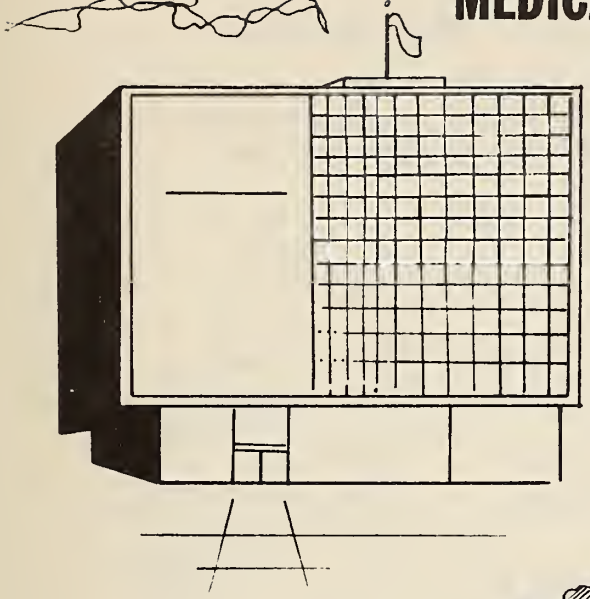
Hospital insurance pays for all covered services--for as many as 100 home health visits after the start of one benefit period and before the start of another.

The visits must be medically necessary and be furnished by a participating home health agency. Benefits can be paid for up to a year after the patient's most recent discharge from a hospital or participating extended care facility if all the following are true:

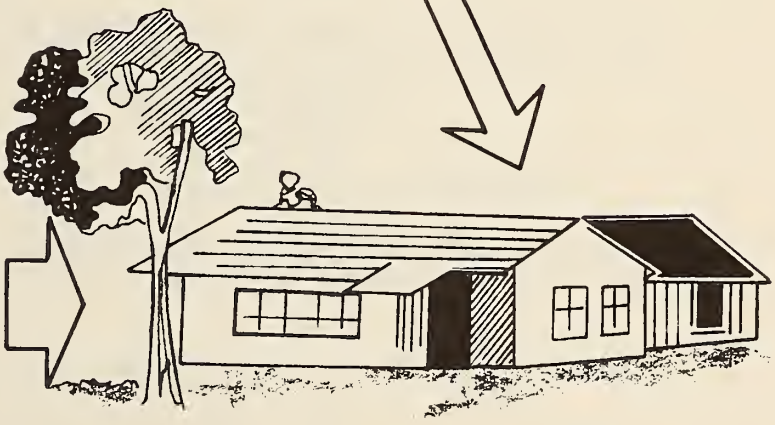
- He was in a participating (or otherwise qualified) hospital for a medically necessary stay of at least 3 days in a row;
- The continuing care he needs includes part-time skilled nursing care or physical or speech therapy;
- He is confined to his own home;
- A doctor determines that the patient needs home health care and sets up a home health plan for him within 14 days after his discharge from the hospital or a participating extended care facility; and
- The home health care is for further treatment of a condition for which the patient received services as a bed patient in the hospital or extended care facility.

MEDICALLY NECESSARY

3 DAY HOSPITAL STAY



CONFINED TO HOME



DOCTOR SETS UP PLAN OF TREATMENT WITHIN 14 DAYS AFTER DISCHARGE

- ***TREATMENT OF A CONDITION FOR WHICH THE PATIENT RECEIVED SERVICES IN THE HOSPITAL OR EXTENDED CARE FACILITY***

Home Health Benefits

The following list describes the kinds of home health services that hospital insurance will help pay for and some of the services that it cannot pay for.

COVERED HOME HEALTH SERVICES

Part-time skilled nursing care.

Physical, occupational, or speech therapy.

Part-time services of home health aides.

Medical social services.

Medical supplies furnished by the agency.

Use of medical appliances.

NONCOVERED HOME HEALTH SERVICES

Full-time nursing care.

Drugs and biologicals.

Personal comfort or convenience items.

Noncovered levels of care.

Meals delivered to your home.

Services not reasonable and necessary for the treatment of an illness or injury.

HOSPITAL INSURANCE HELPS PAY FOR:

- PART-TIME SKILLED NURSING CARE
- PART-TIME SERVICES OF A HOME HEALTH AIDE
- PHYSICAL, OCCUPATIONAL, OR SPEECH THERAPY
- MEDICAL SOCIAL SERVICE
- MEDICAL SUPPLIES & APPLIANCES

DOES **NOT** PAY FOR:

- FULL TIME NURSING CARE
- DRUGS AND BIOLOGICALS
- COMFORT OR CONVENIENCE ITEMS
- NONCOVERED LEVELS OF CARE
- MEALS DELIVERED TO THE HOME

Medical insurance helps pay for doctors' services, outpatient hospital services, medical services and supplies, home health services, outpatient physical therapy, and other health care services.

Terms to know

COVERED SERVICES:

These are the kinds of service medical insurance can help pay for.

$50 DEDUCTIBLE:

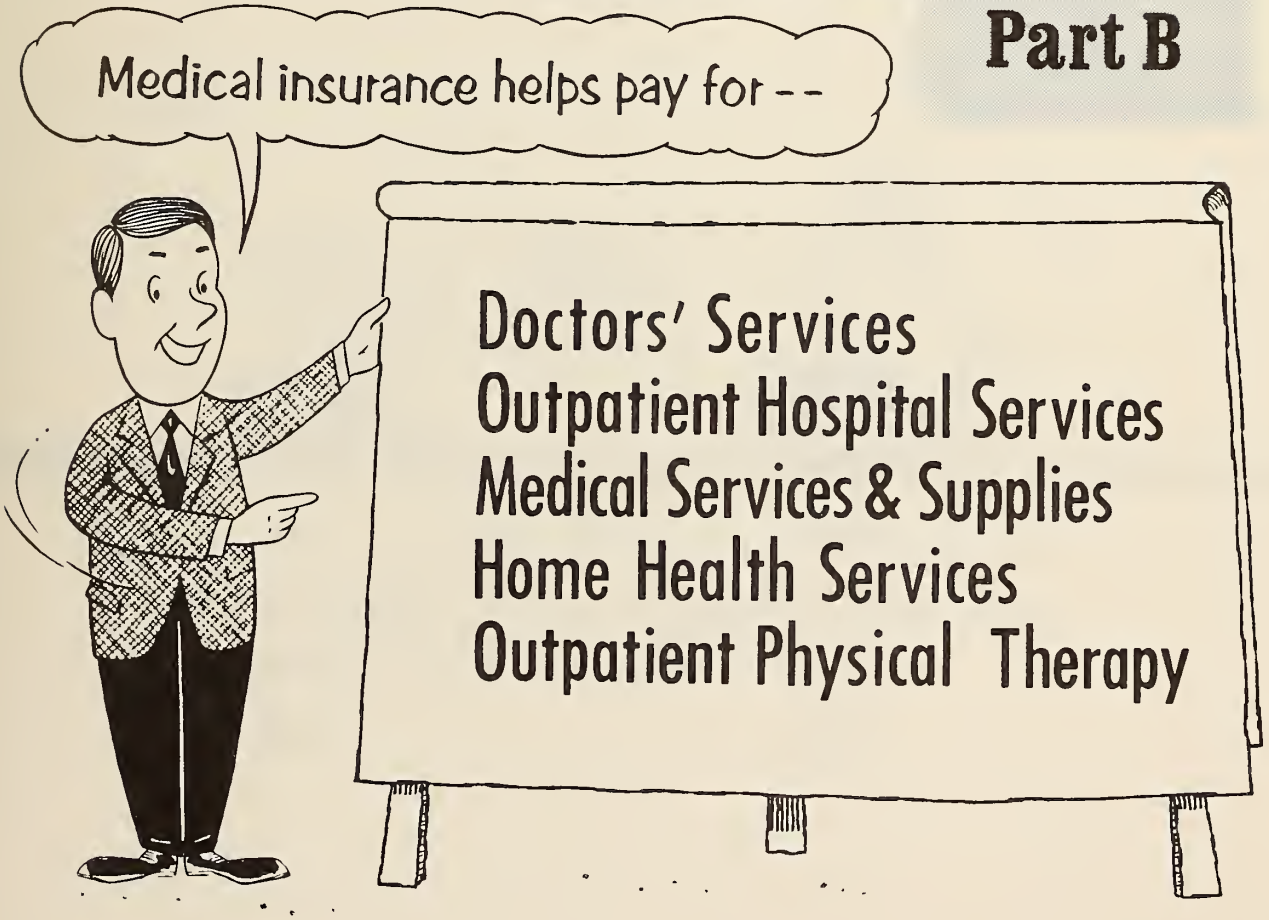
For each calendar year, medical insurance does not pay any of the first $50 of reasonable charges for covered services.

REASONABLE CHARGES:

Reasonable charges are determined by the Medicare carriers--the organizations selected in each State by the Social Security Administration to handle medical insurance claims--and take into account the customary charges of the doctor as well as the charges made by other doctors in the locality for similar services.

Medical Insurance

Part B



Who pays for it?

A monthly premium is paid by the beneficiary ($5.60). This premium covers half the cost of medical insurance protection. The Federal government pays the other half.

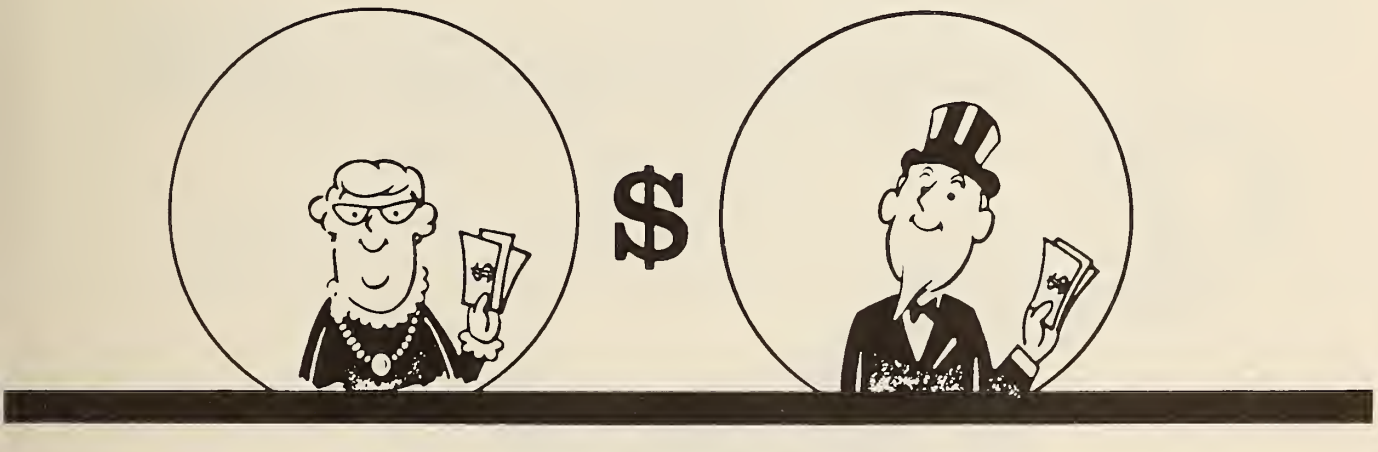
The premium rate must be reviewed annually. If necessary, the rate is changed to make sure that the total amounts collected in premiums and the equal amounts provided by the government will continue to meet the full costs of the program.

Note Those who delayed signing up for a long period of time after their first chance or who signed up again after canceling it in the past are required by law to pay an additional 10 percent for each full year they were eligible but not enrolled.

Example Eligible but not enrolled:

one year or longer $6.20
two years or longer $6.70
three years or longer $7.30

HOW ARE MEDICAL INSURANCE BENEFITS FINANCED?



THE BENEFICIARY PAYS HALF

THE FEDERAL GOVERNMENT PAYS HALF

Payment For Covered Services

After Medicare records show that the beneficiary's bills for covered services are over $50 for a calendar year, medical insurance will pay 80 percent of the reasonable charges in excess of the initial $50 for the rest of that year.

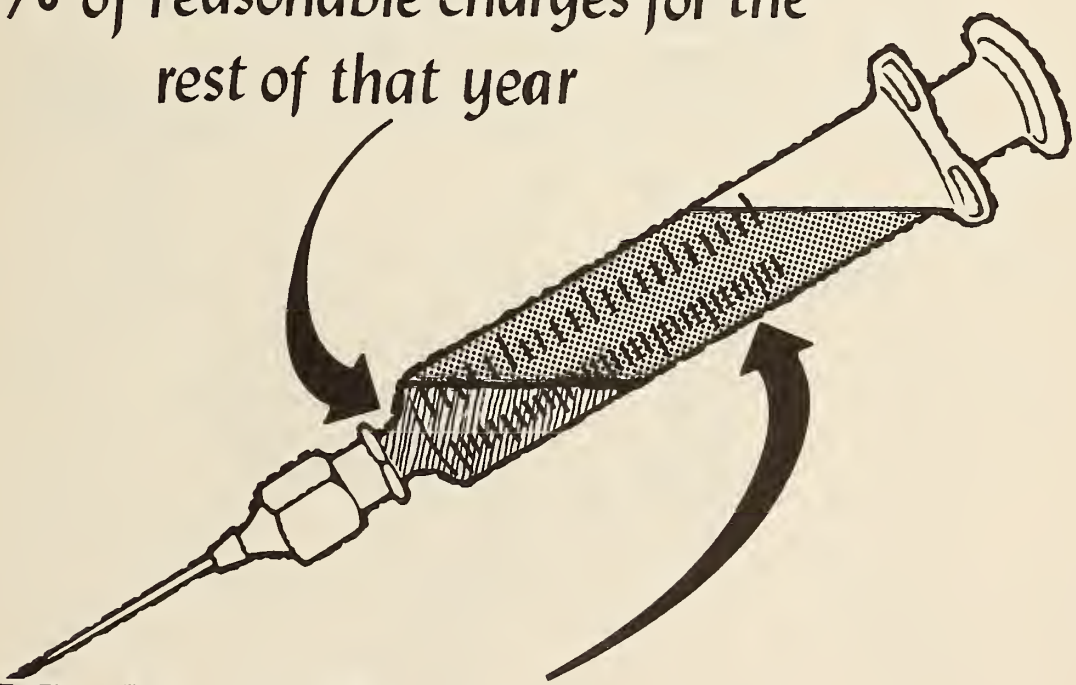
Therefore, the beneficiary is responsible for payment of the first $50 for covered services plus 20 percent of any other reasonable charges for the rest of that year.

Note — There is only one $50 medical insurance deductible each year--not a separate $50 deductible for each kind of covered service. Also, medical expenses in the last 3 months of one year can sometimes count toward the $50 deductible for the next year.

WHO PAYS FOR ***COVERED SERVICES*** ?

- **Beneficiary** *pays first $50 of reasonable charges for covered services*

  20% *of reasonable charges for the rest of that year*



- **Medical Insurance**

  Pays **80%** *of reasonable charges for the rest of that year*

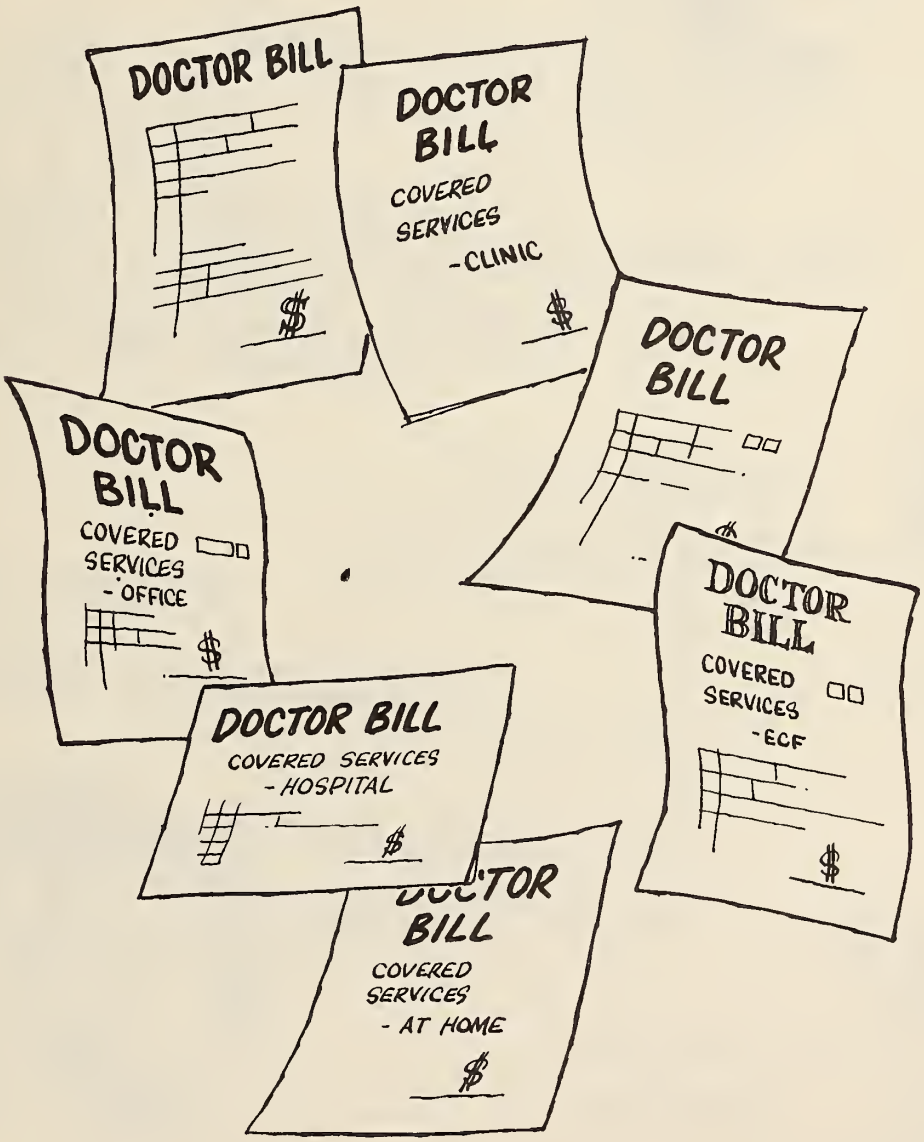
Services Rendered by a Doctor

Medical insurance will help pay for doctor bills for all covered services received in the United States. The doctor may treat a beneficiary in his office, a hospital, an extended care facility, the beneficiary's home, or at a group practice or other clinic.

Payment for covered services received can be made either to the doctor or the beneficiary. (Payment to the doctor is dependent upon his accepting assignment.)

Note Assignment--the doctor (or supplier) must agree that he will apply for medical insurance payments to be made directly to him. Also, he must agree that his total charge will not exceed the reasonable charge.

MEDICAL INSURANCE WILL HELP PAY FOR DOCTOR BILLS



ALL COVERED SERVICES RECEIVED IN THE U.S.

What Doctor Services are Covered?

- Medical and surgical services by a doctor of medicine or osteopathy.

- Certain medical and surgical services by a doctor of dental medicine or a doctor of dental surgery.

  Services of a dentist which involve surgery of the jaw or related structures or setting of fractures of the jaw or facial bones.

- Services by a podiatrist which they are legally authorized to perform by the State in which they practice.

- Other services which are ordinarily furnished in the doctor's office and included in his bill such as:

  Diagnostic tests and procedures
  Medical Supplies
  Services of his office nurse
  Drugs and biologicals which cannot be self-administered.

COVERED SERVICES...

- Medical and surgical services by a doctor of medicine or osteopathy

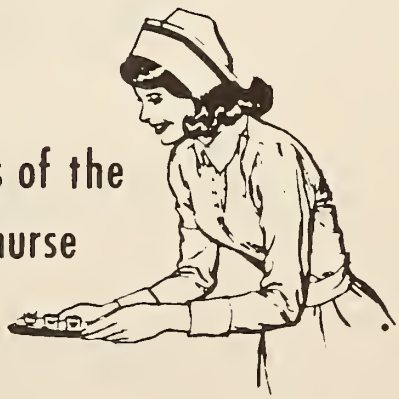
- Certain services by a doctor of dental surgery

- Legally authorized services of a podiatrist

Other services provided by the doctor-

- Diagnostic tests and procedures

- Services of the office nurse



- Medical supplies

- Drugs and biologicals which can not be self-administered

Medical insurance does not pay for . . .

- Routine physical checkups
- Routine and certain other foot care and supportive devices for the feet
- Eye refractions and examinations for prescribing, fitting, or changing eyeglasses
- Hearing examinations for prescribing, fitting, or changing aids
- Immunizations (Unless directly related to an injury or immediate risk of infection such as an anti-tetanus shot given after an injury)
- Services of certain practitioners, for example:

  Christian Science Practitioners

What services are **NOT** covered by Medical Insurance?

• PART B DOES NOT INCLUDE:

1. ROUTINE PHYSICAL CHECK-UPS, EYE EXAMS, DENTAL CARE
2. ROUTINE FOOT CARE
3. EYEGLASSES - FITTING OR CHANGING
4. HEARING AIDS - FITTING OR CHANGING
5. IMMUNIZATIONS NOT RELATED TO INJURY OR IMMEDIATE RISK OF INFECTION
6. SERVICES OF CERTAIN PRACTITIONERS:

   FOR EXAMPLE···

   - Christian Science Practitioners
   - Chiropractors
   - Naturopaths

Special Attention

- Medical insurance pays (100 percent of) the reasonable charges by doctors for radiology and pathology services received as an in-patient, in a participating or otherwise qualified hospital.

  SPECIAL RULE: Because the full reasonable charges are taken care of when the beneficiary receives laboratory and radiology services as a hospital inpatient his expenses for such services do not count toward the $50 deductible.

- Medical insurance will help pay for ambulance transportation by an approved ambulance service to a hospital or skilled nursing home only when:

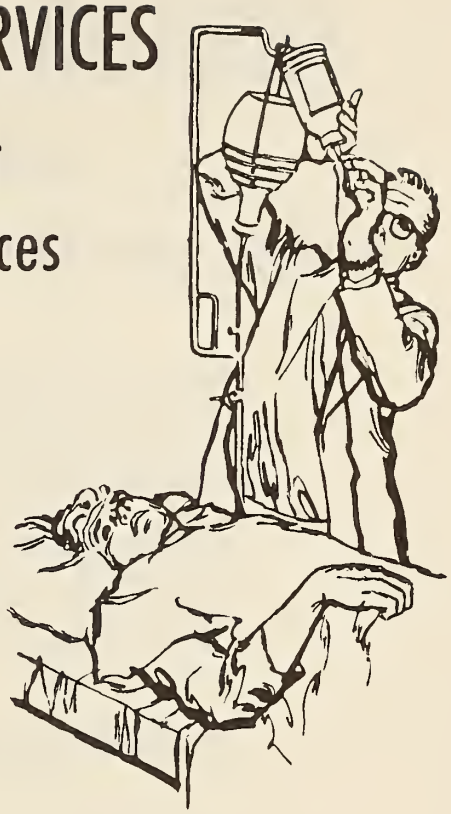
  (1) the ambulance, its equipment and personnel meet Medicare requirements

  (2) transportation by other means could endanger the patient's health, and

  (3) the patient is taken to a facility serving the locality; or the nearest facility that is equipped to take care of him.

Under similar restriction, medical insurance can help pay for ambulance services from one hospital to another, from a hospital to a skilled nursing home, from a hospital or skilled nursing home to the patient's home if his home is in the same locality as the hospital or skilled nursing home.

RADIOLOGY & PATHOLOGY SERVICES



- 100% of reasonable charges for Radiology and Pathology Services received as an inpatient in a hospital

AMBULANCE SERVICES-

- HOSPITAL
- EXTENDED CARE FACILITY
- HOME

- Medical Insurance will help pay for ambulance service under certain conditions

What are Outpatient Hospital Benefits?

When the beneficiary goes to the hospital for diagnosis or treatment and is not admitted as a bed patient, the services they receive are called outpatient hospital services.

Medical insurance pays for 80 percent of the reasonable charges after the $50 deductible has been met. The beneficiary is responsible for 20 percent of the remaining reasonable charges.

What Outpatient Services are covered?

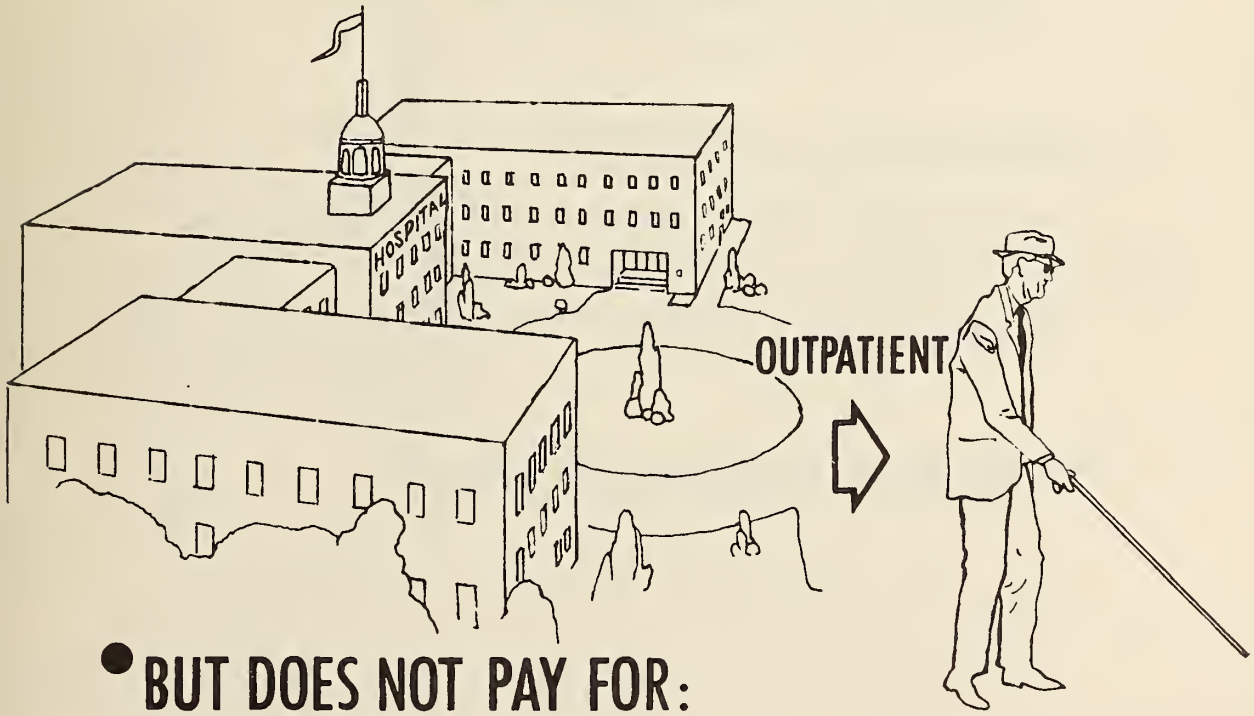
Laboratory services
X-ray and other radiology services
Emergency room services
Medical supplies such as splints and casts
Other diagnostic services

What Outpatient Services are not covered?

Tests given as part of a routine check-up
Eye refractions and examinations for prescribing, fitting, or changing eyeglasses
Immunizations (unless directly related to an injury or immediate risk of infection such as an antitetanus shot given after an injury)
Hearing examinations for prescribing, fitting, or changing hearing aids

OUTPATIENT HOSPITAL BENEFITS

- **Medical Insurance Helps Pay For:**
  - ▸Laboratory and other diagnostic services
  - ▸X-ray and radiology services
  - ▸Emergency room services
  - ▸Medical supplies
  - ▸Other diagnostic services



- **BUT DOES NOT PAY FOR:**
  - ▸Tests given as part of routine check-up
  - ▸Eye refractions and examinations
  - ▸Immunizations
  - ▸Hearing examinations

Home Health Benefits

Medical insurance will help pay for up to 100 home health visits each calendar year, if all the following are true:

- The patient needs part-time skilled nursing care, or physical or speech therapy;
- He must be confined to the home;
- A doctor must determine his need for home health care;
- His doctor must set up and periodically review the plan for home health care; and,
- The home health agency must be participating in Medicare.

How are visits counted?

One "visit"is counted each time the beneficiary receives a covered health care service from a home health agency. If he receives two different services on the same day (for example, both a nurse and a physical therapist) that would be two visits. It would also be two visits if the beneficiary received the same service twice in a day (such as two calls by a nurse).

A DOCTOR DETERMINES THE NEED FOR . . .

Home Health Care

- A DOCTOR SETS UP AND PERIODICALLY REVIEWS A PLAN FOR HOME HEALTH CARE

if

- THE BENEFICIARY NEEDS PART-TIME SKILLED NURSING CARE OR PHYSICAL OR SPEECH THERAPY

AND IS

- CONFINED TO HOME

- THE HOME HEALTH AGENCY MUST BE PARTICIPATING IN **MEDICARE**

Other medical services and supplies

Medical insurance will help pay for a number of different medical services and supplies which may be necessary in the treatment of an illness or injury. They may be furnished in connection with treatment by the doctor, a medical clinic, or other health facility.

The following list shows the kinds of medical services and supplies that medical insurance can help pay for:

- Diagnostic tests such as X-rays and laboratory tests furnished by approved independent laboratories.
- Radiation therapy.
- Portable diagnostic X-ray services furnished in your home under a doctor's supervision.
- Surgical dressings, splints, casts, and similar devices.
- Rental or purchase of durable medical equipment prescribed by a doctor to be used in your home, e.g., a wheelchair, hospital bed, or oxygen equipment.
- Devices (other than dental) to replace all or part of an internal body organ. This includes corrective lenses after a cataract operation.
- Certain ambulance services.

NOTE: If a patient is in a hospital or extended care facility and, for some reason, hospital insurance cannot pay for these services (for example, because they have used up their benefit days), medical insurance can help pay for them.

MEDICAL SERVICES AND SUPPLIES

Part B Helps Pay For:

- DIAGNOSTIC TESTS SUCH AS X-RAY AND LABORATORY TESTS
- RADIATION THERAPY
- SURGICAL DRESSINGS, SPLINTS, CASTS, AND SIMILAR DEVICES
- RENTAL OR PURCHASE OF DURABLE MEDICAL EQUIPMENT
- DEVICES TO REPLACE ALL OR PART OF AN INTERNAL BODY ORGAN
- CERTAIN AMBULANCE SERVICE

Part B Does Not Pay For:

- PRESCRIPTION DRUGS AND DRUGS THAT CAN BE ADMINISTERED BY THE BENEFICIARY
- HEARING AIDS
- EYEGLASSES
- FALSE TEETH
- ORTHOPEDIC SHOES OR OTHER SUPPORTIVE DEVICES FOR THE FEET

Additional copies of this booklet can be obtained by contacting your servicing SSA, Health Insurance Regional Office or by writing to Social Security Administration, Bureau of Health Insurance, Division of Management, Management Resources Branch, Baltimore, Maryland 21235.